Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Elite Healthcare Fort Worth

Respondent Name
Ace American Insurance Co

MFDR Tracking Number
M4-15-1812-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
February 18, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…Patient also has authorization for physical therapy in our office."

Amount in Dispute: $561.98

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…we have escalated the bills in question for manual review to determine if additional monies are owed."

Response Submitted by: Gallagher Bassett, 6404 International parkway, Suite 2300, Plano, TX 75093

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 16, 2014	Professional Medical Services	$561.98	$561.98

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.210 sets out the guidelines for medical documentation.
3. 28 Texas Administrative Code §134.600 sets out guidelines for prospective and concurrent review of health care.
4. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication
   - 8 – The procedure code is inconsistent with the provider type/specialty
   - B12 – Services not documented in patients' medical records

Issues

1. Did the requestor support the services as billed?
2. Were the services in dispute authorized?
3. What is the rule applicable to reimbursement?
4. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the disputed services as B12 – "Services not documented in patient's medical records." Per 28 Texas Administrative Code §§133.210(a) states in relevant portion, "Medical documentation includes all medical reports and records, such as evaluation reports, narrative reports, assessment reports, progress report/notes, clinical notes, hospital records and diagnostic test results." Review of the submitted documentation finds;
    a. 99214 – "Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family." Review of record submitted finds;
        i. Status of Chronic Conditions: (1) condition.
        ii. History of present illness: (3)
        iii. Review of systems: (1) musculoskeletal. Submitted code requires 2 – 9 systems. Documentation requirements not met
        iv. Past medical, family, social history (1)). Submitted code requires 1 history area. Documentation met

        Examination: Body areas; (1) Each extremity. Organ systems: (1) Musculoskeletal. Submitted code requires Up to 7 systems. Documentation met.

    The Division finds two of the three key components required for the submitted code are met. The Carrier's denial is not supported. The disputed code will be reviewed per applicable rules and fee guidelines.
2. Per 28 Texas Administrative Code §134.600 (p) (5) Non-emergency health care requiring preauthorization includes: Common Procedure Coding System (HCPCS) at the following levels: (A) Level I code range for Physical Medicine and Rehabilitation,,,," Review of the submitted documentation finds that prior authorization was obtained for the following:
    a. Requested Service Description: Physical therapy 6 sessions left elbow 97110 97112 97140
    b. Certified quantity 6 physical therapy
    c. Start date: 08/28/14 End date: 11/28/14

    28 Texas Administrative Code §134.203 (c) states in relevant portion, "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (date of service yearly conversion factor). As the services in dispute were authorized and supported by medical documentation the maximum allowable reimbursement will be calculated as follows;

Date of service	Submitted code	Units	Maximum allowable reimbursement (MAR) (TDI-DWC Conversion factor / Medicare conversion factor) x non-facility price = MAR
September 16, 2014	99214	1	55.75 / 35.8288 x $106.56 = $165.84
September 16, 2014	97140	2	55.75 / 35.8288 x 29.86 = $6.47 x 2 units = $92.94
September 16, 2014	97112	2	55.75 / 35.8288 x $33.41 = $52.00 x 2 units = $104.00
September 16, 2014	97110	1	55.75 / 35.8288 x $32.00 = $49.80 x 4 units = $199.20
		Total	$561.98

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $561.98.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $561.98 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		March , 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.